FORM D
VERIFICATION OF CLINICAL CLERKSHIPS

INSTRUCTIONS: International graduates who have done clinical clerkships in the United States should send this form to each institution to have clerkships verified. The Institution should complete the form and return it to you in a **sealed envelope. Have the institution stamp their seal across the back of the envelope. Do not open the envelope**; send it with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

NAME OF APPLICANT

US SOCIAL SECURITY NUMBER

			-			-				

DATE OF BIRTH

MM/DD/YY

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM/TO (MONTH/DAY/YEAR)	PROGRAM DIRECTOR'S NAME

G M B U S E O N L Y
AMA/AOA YEAR _____
AMA/AOA PAGE # _____

G M B U S E O N L Y
AMA/AOA YEAR _____
AMA/AOA PAGE # _____

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AMA/AOA YEAR _____
AMA/AOA PAGE # _____

ATTENTION PROGRAM DIRECTOR OR REGISTRARS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the Program Director or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

I _____
FULL NAME OF PROGRAM DIRECTOR OR REGISTRAR(PLEASE TYPE OR PRINT)

_____
SIGNATURE OF PROGRAM DIRECTOR OR REGISTRAR

DECLARE UNDER PENALTY OF PERJURY, THAT I AM/WAS THE PROGRAM DIRECTOR OR REGISTAR FOR THE STUDENT NAMED ABOVE, THAT I HAVE CAREFULLY READ THIS FORM, AND THAT THE STATEMENTS MADE HEREIN ARE STRICTLY TRUE IN EVERY ASPECT.